

Editorial

Towards a more nuanced global mental health

Ross G. White and S. P. Sashidharan

**Summary**

The World Health Organization has made concerted efforts to scale up mental health services in low- and middle-income countries through the Mental Health Gap Action Programme (mhGAP) initiative. However, an overreliance on scaling up services based on those used

in high-income countries may risk causing more harm than good.

Declaration of interest

None.

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The World Health Organization (WHO) has estimated that four out of five people in low- and middle-income countries (LMIC) who need services for mental, neurological and/or substance use disorders do not receive treatment.¹ This has been referred to as the treatment gap; the difference between the level of mental health provision that is required and the actual level of support that is available. In an effort to increase (or scale up) mental health provision in LMIC, the WHO published two key documents: *Mental Health Gap Action Programme*¹ (mhGAP-AP) and *mhGAP Intervention Guide*² (mhGAP-IG). The mhGAP-AP outlines key steps for scaling up mental health services in LMIC, and the mhGAP-IG presents integrated management plans for priority conditions including: depression, psychosis, bipolar disorder and epilepsy in LMIC. Although acknowledging that the WHO initiatives (along with the two *Lancet* series on global mental health) have undoubtedly increased awareness about mental health difficulties in LMIC, there is a need to critically reflect on the strategic direction that the mhGAP initiative has taken and consider whether this is the most productive way to proceed. This reflection is particularly timely in light of the adoption of the *Mental Health Action Plan 2013–2020*,³ which has been based on global and regional consultations.

The ubiquitous use of medication

Contained within mhGAP-IG there are templates for 'evidence-based interventions' that can be adapted for use in different countries to address a range of psychiatric, substance use and neurological disorders that are identified as priority conditions. This is in spite of there being ongoing debate about the cross-cultural validity of psychiatric diagnoses such as depression.^{4,5} The first line of treatment recommended in many of the mhGAP-IG templates for intervention is psychotropic medication. It is important to consider whether there is sufficient justification for this being the case. Unlike physical health problems (e.g. polio, influenza, HIV), the evidence for biomedical *causes* of mental illnesses (such as depression and schizophrenia) remains fairly weak.^{6,7} There is also growing evidence that aligning the treatment of mental health difficulties too closely to a biomedical model may have potentially detrimental effects. For example, a reliance on

biomedical causal explanations of mental health difficulties has been associated with increased prejudice, fear and desire for distance from individuals diagnosed with psychiatric disorders.⁸ Although, psychotropic medication can be helpful in managing distress, there are also limitations to this approach that the mhGAP initiative fails to address. For example, long-term use of antipsychotic medications can contribute to increased morbidity (including metabolic disorders and cardiovascular conditions), and risk of premature mortality linked to sudden cardiac death.⁹ Research indicates that reducing or discontinuing the doses of antipsychotic medication in the early stages of remission from first-episode psychosis is actually associated with superior recovery compared with maintenance treatment with antipsychotics.¹⁰ Important questions have also been raised about the methodologies employed by pharmaceutical companies to evidence the effectiveness of psychotropic medication.¹¹

There is a danger that biomedical explanations of mental health difficulties and an overreliance on psychotropic medication may serve to inhibit the utilisation of alternative forms of support. This is an important issue that merits careful consideration by those involved in scaling up services for mental health in LMIC. It has been argued that a lack of academic and political engagement with alternative, non-Western perspectives about mental health problems means that Western narratives about 'mental illness' dominate over local understanding.^{12,13} Although mhGAP-AP and mhGAP-IG both highlight the importance of 'integrated' treatment packages that include both medication and psychosocial interventions, there is no acknowledgement of how the availability of these interventions may inhibit pluralism and the use of other forms of healing and/or support.

Establishing evidence-based services . . . or not

The mhGAP initiatives highlight the importance of scaling up evidence-based interventions. However, the financial, human and technical resources available for conducting research in LMIC to establish an evidence base for mental health interventions are very limited.¹⁴ Indeed, the challenges associated with establishing evidence-based approaches are highlighted in the following extract from the mhGAP-AP:¹

'Scaling up is defined as a deliberate effort to increase the impact of health-service interventions that have been successfully tested in pilot projects so that they will benefit more people [. . .] However, pilot or experimental projects are of little value until they are scaled up to generate a larger policy and programme impact' (p. 13).

On one hand, there is a tacit acknowledgement of the importance of doing pilot research to verify the acceptability and effectiveness of interventions; and on the other, there is an assertion that scaling up needs to occur before this evaluation can take place. We propose that this reasoning is fundamentally flawed. A key question that needs to be addressed is: is this approach ethical?

Although we acknowledge the pressing need to support the mental health needs of people across the globe, this should not happen at the risk of causing harm. Research conducted by the WHO has indicated that outcomes for serious mental disorders are not superior in high-income countries relative to LMIC (where populations may not have access to medication-based treatments).¹⁵ An examination of the academic discourse that followed the dissemination of the findings concluded that strenuous efforts were made to 'preserve an image of Western superiority and Third World inferiority'.¹⁶ If the psychiatric services that are generally offered in high-income countries are failing to deliver, then great caution should be exercised in using these as a benchmark for scaling up similar services in LMIC. It has been suggested that better outcomes for complex mental health difficulties in LMIC may be a consequence of the multiplicity of treatment/healing options available in LMIC compared with high-income countries.¹⁷ Unfortunately, the types of services advocated by the mhGAP initiatives largely mimic the approach to service design that is currently advocated in high-income countries and do not embrace medical pluralism.

Services that reflect the beliefs and practices of local people

One of the key limitations of the mhGAP initiatives is the lack of emphasis that is placed on the potential role that social and cultural factors play in mental health problems across the globe. The mhGAP-AP acknowledges that 'social and cultural factors' are examples of demand-side barriers that may limit individuals' willingness to engage with mental health interventions in LMIC,¹ but it does not elaborate on how these factors should inform the development of services. We believe that the design, development and implementation of services to support the mental health needs of particular populations will need to be embedded in qualitative research that will directly inform this process and tailor it to the needs of local populations. This process will require the involvement of a wide range of stakeholders. We are concerned that the mhGAP initiatives did not involve sufficient consultation with individuals with a lived experience of mental health difficulties about what constitutes good services for mental health in LMIC. This lack of consultation is a criticism that has been made of mental health services in high-income countries.

In our view, the failure of the mhGAP initiatives to recognise the limitations of the biomedical and institutional models of healthcare undermines the validity, relevance and appropriateness of the approach that it advocates. We appreciate that there are inherent risks associated with managing the tensions between the urgency with which services need to be scaled up, and on the other hand ensuring that this is done in an ecologically valid, ethical and sustainable way. The growing connectivity, integration and interdependence between people across the world can create great opportunities for progress. But these networks of connectivity are only as good as the ideas that are shared. We must critically reflect on the merits of biomedical conceptualisations of mental health and weigh these with local perspectives and local resources (including indigenous healing, social support networks, rights-based organisations and family support).

Looking to the future

In June 2013, the WHO adopted the *Mental Health Action Plan 2013–2020*.³ This outlines four key objectives:

- (1) strengthen effective leadership and governance for mental health
- (2) provide comprehensive, integrated and responsive mental health and social care services in community-based settings
- (3) implement strategies for promotion and prevention in mental health
- (4) strengthen information systems, evidence and research for mental health.

It is hoped that this plan with its global focus, support for the involvement of people with lived experiences of mental health problems, and emphasis on mental health promotion (rather than a narrow focus on mental illness) will go some way to facilitating greater reciprocity between high-income countries and LMIC in efforts to produce innovation in mental health services. Only by engaging in critical reflection about how mental health services are designed and delivered in both high-income countries and LMIC can we foster a global mental health that is truly global. Global mental health is a worthy quest, but it is a quest that needs to be receptive to the wealth of beliefs and practices espoused by the diverse populations that it seeks to serve. Moving forward there is a need to ensure that: a more balanced exchange of knowledge occurs between high-income countries and LMIC; greater credence is given to diverse explanatory models of distress; sociocultural influences on mental health are better understood; and individuals are facilitated to find meaning in their experience, irrespective of where they are on the globe.

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reflection

On *Regeneration* (from the *Regeneration Trilogy*) by Pat Barker

Sharon Singsit-Evans

Regeneration in a living organism is defined as the process of re-growing of new tissues after loss or damage. It has become synonymous for example, in theology, with the revival of one's soul, and in socioeconomics, with investment into areas of deprivation. This reminds me of *Regeneration*, Pat Barker's novel, of the use of this term to describe the process of recovery from psychological trauma in soldiers during the First World War. In this novel, historical figures and some fictional characters are interspersed to recreate an account of embattled soldiers receiving treatment at Craiglockhart War hospital, near Edinburgh.

Psychological trauma, feelings of entrapment, attachment to significant others, relationships and healing are all core experiences of humanity, both during war and in peacetime. Neurotic disorders arising out of feelings of entrapment and powerlessness were usually considered to be confined to the female population, who were, so to speak, left behind at home to manage the prevailing circumstances. But in the trenches, the soldiers experienced unprecedented feelings of powerlessness, and of indefinite entrapment. Conversion symptoms such as mutism, phobias, nightmares and dissociative behaviours, appear to have been frequently observed in soldiers having treatment in the war hospital.

Needless to say, it is evident that the physical, social, psychological, emotional and spiritual impact of trauma resulting from wars of any kind or proportion is enormous. The consequent internal vacuum within an individual and society remains a battlefield for conflicting experiences; but where enemies were visible and fought against in a war, the enemy was now undoubtedly invisible and within the self.

I think that for many, the challenges of modern life may feel like an entrapment, but the present pace of life does not allow the time, space and opportunities for people to talk about their difficulties, and to be heard. I also encounter people who simply have no words to describe their suffering. It seems to me the mutism exhibited by some of the soldiers in the novel, and by my patients today, is conceivably a marker of the depth of the unspeakable pain and anguish they have experienced.

I am intrigued by Dr W. H. R. Rivers, an English anthropologist, neurologist and psychiatrist who worked at Craiglockhart during 1916–17. Previously he had conducted experimental research into nerve regeneration, apparently even using himself as a subject. His interest in the origin of symptoms or experiences clearly was not restricted to a biological model; given his background, he was also deeply aware of the social and psychological reasons for the varying expressions of distress. He faced a battle to convince his superiors about the morality of enforced treatment to 'regenerate' the soldiers in order to return them to battle. He observed treatment approaches which on the surface appeared harsh. He dealt with empathy the potential painfulness for an already troubled mind, of enduring his seemingly gentler and kinder treatment of talking, recounting the experience of trauma. His approach helped his patients to move on to develop a trusting attachment, and thus begin the process of regeneration. It illustrates the power of a therapeutic relationship to aid in recovery.

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